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ORIGINAL PAPER

In the Fertile Minefield: Navigating Challenges and Opportunities with Facilitating Self-development and Growth in the Intercultural and Interracial Clinical Treatment Dyad

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Abstract
The "use of self" is a powerful tool that social workers rely upon to facilitate treatment growth for their clients. Yet, for many ethnic and racial minority clinicians, their self contains personal, psychological, social, and cultural aspects that they must acknowledge, examine and negotiate as they enter into the clinical arena. The therapeutic world is increasingly diverse, therefore, the profession must address issues relating to researching, educating, training, supervising, and supporting clinicians from diverse backgrounds to attend with greater knowledge and self-examination. They must attend to the nuances of use of self with respect to issues of intersectionality in order to provide attuned, culturally responsive, and socially just treatment. This paper demonstrates how clinical social work practitioners can facilitate self-development and growth in clients through their strategic use of self as grounded in early British and American object relations theories and contemporary relational theory. The clinical materials in the composite case study (employed to protect the confidentiality of the clients) are used to illustrate that when clinicians embrace the challenges of working in the intercultural and interracial treatment arena and dive deeply beyond the choppy surface, there are many opportunities to further the therapeutic progress while providing a culturally sensitive and socially just clinical practice. Implications for clinical social work practice, education and research are identified.

Keywords Self-development and integration · Use of self · Intercultural and interracial treatment · Dynamic practice · Intersectionality

Introduction

Since its inception, the clinical social work profession has privileged the importance of working to support clients' growth and self-development with respect to their unique backgrounds and individualized needs in the context of their social environment (Richmond 1917). In addition, the core values of the social work profession emphasize the dignity and worth of the individual as well as the importance of human relationships in the provision of service delivery, which is central to clinical social work (Workers 2017). Clinical social workers also rely on the use of self as a catalytic agent to facilitate personal growth and change in their clients (Barnard 2012; Dewane 2006; Shaw 1974). Dewane (2006) defines the use of self in social work practice as the social worker embodying the knowledge, values and skills gained in social work education with aspects of one's personal self, including: personality traits, belief systems, life experiences and cultural heritage. As such, the use of self is similar but extends beyond the psychoanalytic concept of countertransference where the analyst's unconscious thoughts and feelings are activated (Racker 1953). It includes an acknowledged presence that is skillfully used and intentionally incorporated into a dynamic and active therapeutic process in the clinical encounter. Last, but most importantly, effective use of self depends on constant reflexivity and robust self-examination. In fact, in her comprehensive and cogent text regarding cultural competence in psychoanalytic theory and psychotherapy, Tummala-Narra (2016) notes, "self-examination is a critical aspect of culturally informed psychoanalytic practice because it shapes what

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is heard by the therapist and how the therapist may approach issues of diversity in psychotherapy" (p. 230).

Acknowledging the impact and intersection of diversity in cultural and life experiences of clients and clinicians, Perez Foster (1999) evocatively asserts that the cross-cultural clinical space is "charged with its terrors, suspicions, and disavowed prejudices, [yet] provides some of the most fertile spaces for minds to collide and collude in their attempts to know each other" (p. 269). Concluding her influential article, Perez Foster (1999) calls for "clinicians to brave the choppy waters of their intersubjective sensibilities and bring the terrors up for air" (p. 289). As an immigrant to the United States (U.S.) and someone often racially and ethnically different from my clients, I argue that clinicians whose racial and cultural social identities are visible have no choice whether to be brave or not. They must face the immediate necessity of navigating and working in unfamiliar and uncertain minefields as their own experiences of "gender, race, ethnicity, religion, dis/ability, language, sexual identity, social class, and immigration come to life explicitly and implicitly in the therapeutic work" (Tummala-Narra 2016, p. 203).

Despite the historical event of emigration of European analysts to the U.S. after the World Wars, there has been little written to center the clinical experiences of immigrant clinicians. Only within the last thirty years has the therapeutic community in the U.S. seen an increase in written scholarship in which the clinician, identified as an immigrant or ethnic outsider, considers the cultural countertransference in great depth (Akhtar 1995; Comas-Diaz and Jacobsen 1995; Kissil et al. 2013; Mattei 1999; Rastogi and Wieling 2005; Tummala-Narra 2016; Yap 2015). Unfortunately, to date, this is still an understudied and underwritten subject matter. The aim of this paper is to add to this scholarship and to further highlight dynamics and transformational processes in intercultural and interracial treatment. Indeed, the therapeutic world is increasingly diverse, therefore, it is time the profession elevates this scholarship and addresses issues relating to educating, training, supervising and supporting clinicians from diverse backgrounds in the use of self in clinical practice.

In this paper, I describe the ways I have facilitated self-development and growth for my clients through the strategic use of self, paying particular attention to and examining my self, one that is racially, ethnically and culturally different than my clients. To ground the discussion, I utilized object relations theory from Margaret Mahler, Melanie Klein, and Donald Winnicott as a theoretical conceptualization framework for self-development. I also relied on relational theory from Stephen Mitchell, Lewis Aron, Jessica Benjamin and multicultural clinicians and writers such as Lillian Comas-Diaz, Lourdes Mattei and Pratyusha Tummala-Narra to navigate the course of intercultural and interracial treatment. I hope the clinical materials in the paper will illustrate that when clinicians embrace the challenges of working in the intercultural and interracial treatment arena and dive deeply beyond the choppy surface, there are many opportunities to further the therapeutic progress and growth. I invite readers to enter the treatment arena and consider the enactments and interactions as phenomenological moments of interracial and intercultural treatment. The structure of the paper is an intentional exposition of my application of the theoretical frameworks and negotiations of the disparate but challenging aspects of psychodynamic treatment as a minority therapist. In highlighting the intersectionalities and multiple perspectives, as well as presenting the voices of both the client and the clinician is another reflection of the parallel process of intersubjective, co-constructive nature inherent in relational treatment.

Selected Review of the Theoretical Literature

Self, Other and Interdependency

For dynamically trained clinical social workers, object relations theories align well with the core social work value of the importance of human relationships (NASW 2017). In fact, object relations theories have naturally resonated with how I have been socialized as an Asian person in the tacit consideration of the self in relation to others. Perhaps, long before I learned about Melanie Klein's concept of 'good breast/bad breast' in the mother, growing up in Vietnam, I understood the duality of *âm* và *dương* or yin and yang and the nature of interdependency of differences and paradoxes in the natural world. Things are often not what they seem to be on the surface. There are many perspectives to one story, and many processes are never linear but rather interactive and cyclical.

Object relations theories shift the understanding of self-development away from a solely intrapsychic process. Object relations theories posit that the self develops in relationship with the object, referring to object other as both people (beginning with mother/caregiver(s) and beyond) as well as external experiences. Object relations theorists identify discrete psychological mechanisms of differentiation and integration via complex processes involving incorporation, introjection, projection and identification in the negotiation of self and others (Flanagan 2011; Hamilton 1988). Essentially, through repeated encounters with objects, individuals observe, identify and incorporate the introjections such as ideas and attitudes from others and the representational world in the creation of internal psychological structures (Flanagan 2011). Contemporary neuroscience has further illustrated the interdependency of nature and nurture and underscored that developmental growth is as

experience-dependent as it is contingent on innate biological processes (Schore 2012; Siegel 2008).

Object Relations Theories of Self-development and Integration

Mahler (1968) outlines the process in which the young child develops through the phases of separation and individuation. Maturity is established with object constancy, a developmental milestone where the child can "hold in mind" the "representation of the other even in the face of absence, disappointment, or anger" (Flanagan 2011, p. 152). While Mahler has provided critical insights regarding the developmental phases, she has not outlined specific techniques to adopt in the treatment beyond classical psychoanalytic interventions. Furthermore, the notion of growth and "independence" from a Mahlerian perspective promotes a Western individualistic "I" self in contrast to cultures that support the collective "we" self (Roland 1996).

Similarly, Klein describes self-growth and maturity culminating in reaching the depressive position whereby the individuals are able to recognize others not as part objects that are either all good or all bad, but as whole objects, containing both good and bad (Segal 1964). This ability allows people to better tolerate ambiguities and manage uncertainties. With the recognition that both good and bad aspects exist in others and in themselves, individuals become aware and acknowledge others and themselves as richly complex and multifaceted beings. However, a limitation of Kleinian analysis is its focus on drive-gratification thereby rely solely on psychoanalytic interpretation and analysis of defenses in the clinical treatment.

Of the different object relations theorists, Winnicott, a British pediatrician and psychoanalyst, articulates interdependent relational aspects between self and others and outlines the most specific clinical interventions to facilitate developmental growth. He suggests that the clinician should mimic the task of the "good enough" mother, defined as a mother or a caregiving substitute, who need not be perfect, but good enough to facilitate growth via corrective or reparative emotional experience (Applegate and Bonovitz 1995; Winnicott 1960). According to Winnicott, healthy development is possible when the good enough mother creates and facilitates a holding environment to provide holding, handling, and presenting to enable the child's sense of "going-on-being." Interactions with others and the external world are also negotiated (Applegate and Bonovitz 1995). Winnicott (1960) further theorizes that the mother creates the holding environment, an environment of consistent, secure and safe space where the child can explore, play and grow. When the child experiences sadness, anger, and a multitude of feelings and self-states, the mother provides holding that facilitates self-integration. She handles the child's crises, gathers all "the bits and pieces," and offers comforts and guidance that contributes to greater personalization. Through this mirroring, in the reflective gaze of the mother, the child sees a reflection of herself as well as experiences her mother's regards for her and thus recognizes her own self-worth and value (Winnicott 1971). Lastly, the mother presents herself and the world to her child, which shape how the baby will relate to the external reality. The child internalizes the care from the mother. Over time, the child learns to self-soothe, an essential pre-cursor for affect regulation and impulse control, which facilitates the capacity to be alone, and ultimately able to engage in mutual and reciprocal relationships (Winnicott 1963a; b).

Through the repeated handling, holding and presenting, the child recognizes ego relatedness, a connection between self and other as she builds the internal psychological structure (Applegate and Bonovitz 1995; Winnicott 1971). This process enables individuals to navigate their subjectivity while recognizing others with their own separate, different subjectivities that support their ability to sustain complex relational interactions toward mature mutual interdependent relationships (Benjamin 2018; Winnicott 1963b). A fundamental aspect of the curative process in object relations theory and relation theory is grounded in the provision of care of the clients with critical empathic attunement and responsiveness that promote clients' felt sense of being seen, heard and understood (Applegate and Bonovitz 1995; Goldstein et al. 2009; Mitchell 2000; Ogden 1994). These theoretical concepts have provided a strong foundational framework guiding my work to facilitate self-development and growth in my clients.

Questions of Multicultural Practice and Intersectionality

The expressed importance of human relatedness and connection is an essential and implicit strength of object relations theories and treatment approaches. However, as an ethnic immigrant, I wonder about the issues of relatedness where the therapeutic dyad includes two people with very different racial and ethnic selves. How do racial and ethnic differences influence the transference? As a result, can the clinician fully hear and understand the client? Can the clients see themselves as reflected from the ethnic other clinician? How will they see each other? How must they negotiate the visible as well as unseen, unconscious assumptions?

A perennial concern of clients is whether the clinician truly hears or understands them, and this can be even more pronounced if they hear that the clinician has accented pronunciations, assume or know that English is the clinician's second language (Seelye 2005; Shonfeld-Ringel 2000). Of course, anyone who has ever learned or attempted to use a foreign language will understand there are multiple layers

and meanings to words, utterances, and behaviors that are contextually dependent on the social and cultural context. One can be fluent in a given language yet unable to grasp jokes and understand colloquialisms due to embedded cultural connotations. Therefore, the potential for misunderstanding and misconnection is inevitable.

It is also reasonable that U.S. born clients may make assumptions about the immigrant clinicians. They may wonder, "If you do not look like me, have not lived my life, you are not knowledgeable about my world and me," and therefore might question, "How will you be able to understand and help me?" As a corollary, an immigrant clinician in the position of being the outsider may be perceived as less competent than another clinician from the dominant culture (Comas-Diaz and Jacobsen 1991; Kissil et al. 2013; Rastogi and Wieling 2005).

Major Challenges and Opportunities in Intercultural and Interracial Treatment

Perhaps the most challenging dilemma that occurs in the intercultural and interracial arena is when immigrant clinicians find themselves in a "double bind about whether to take a therapeutically neutral position and risk colluding in their own marginalization and othering" (Lee 2005, p. 99), or risk disrupting the therapeutic alliance by pointing out the disturbing contagion of racial, social and cultural oppression (Garran 2013). In my practice experience, particularly as an ethnic immigrant, my clients often begin the treatment with an interesting game of "name the Asian" in what seems like an attempt to locate me. Once the clients triumphantly guess or identify that I am Vietnamese (either from my name or physical features), they talk at length about family members who have been in the Vietnam War—the war I knew as the American War. Regardless of the speakers' ideologies and relationships with the Vietnam War, I am left with their dual view of me and other Vietnamese people only as: (1) exotic singular others and (2) people pinned in the footnote of a shameful sociopolitical, historically unpopular American War.

Without a doubt, when looking at racial or ethnic minority clinician, clients often see first the personal and cultural before the professional identity. Indeed, as my clients have rightfully reminded me, besides my professional self, a physical and visible presence in the clinical space is my personal, social and cultural self that cannot be hidden unlike white clinicians who can hide within the assumed norm and unexamined whiteness. Therefore, what is "hidden in plain sight" in this racially and ethnically different therapist presents an inherent challenge for management of therapeutic neutrality (Bromberg 2013). Because it is inevitable that clients will project onto me, a "colored screen", it is necessary for me to skillfully navigate and manage the "cultural countertransference" and use of self (Comas-Diaz and Jacobsen 1991; Perez Foster 1999). I must take into account how the clients see me as well as how my lived experiences of intersectionality—a multiple and simultaneous discrimination and oppression due to social identities as related to race, sex, class, gender, migration, and colonization—have affected my ability to practice, and to provide a dynamic facilitation of self-growth and integration within a culturally responsive framework (Crenshaw 1991; Dill-Thornton and Zambrana 2009; Mehrotra 2010; Tummala-Narra 2016).

Lastly, it is important to keep in mind that in addition to these challenges, there are also opportunities in the interracial and intercultural treatment dyads. Kissil et al. (2013) suggest that with immigrant clinicians who are "not from here", clients may give them some considerations for not knowing the local customs and mores and therefore, would tolerate further inquiries by the clinician. Furthermore, being from elsewhere, the immigrant therapists, with a different lens, may see things with new and different perspectives. This is a useful reminder that any clinician in any therapeutic dyad is essentially an "outsider." The clinician is a guest who has been invited into the world of the client with their own landscape, history and cultural mores that suggest important implications for engagement, establishing therapeutic alliance and maintaining treatment processes towards optimal outcomes.

Relational Theories and Practice

Object relations theory has guided my conceptualization in how to facilitate self-development and growth for clients, however, it does not offer a way to navigate the intersectionalities and intersubjectivities. It proved necessary for me to engage the clients through the relational treatment lens. Relational theory recognizes there are two people and multiple subjectivities in the clinical setting. It demands a reformulation beyond either/or but a both/and perspective, which include the therapist's subjectivity and co-construction (Aron 1996; Benjamin 2004; Mitchell 2000; Ogden 1994). Aron (1996) writes that it is not just the client who is the subject of study or is changed; rather, each member of the dyad is equally and mutually influencing the other and the treatment process. In this respect, relational theorists reconfigure the hierarchical power inherent in the classical treatment relationship and suggest there are more similarities than differences in each person's subjectivity and interactional dynamics. Just as the client recreates their early object relations so does the clinician.

In so doing, relational theorists identify multiple shifts in the positionality of the client and the therapist that demand a reformulation of countertransference and enactments. This perspective rejects the notion of the therapist as a blank slate and considers therapeutic neutrality not only as

a futile quest, but potentially harmful (Mitchell 2000; Wachtel 1986). Therefore, relational theory in its formulation regarding the dynamic and interactive nature of meeting, understanding and working with others aligns and provides useful guidance for interracial and intercultural practice. Relational theory and practice require clinicians to consider their experiences as well as those of their clients in terms of their personal, psychological, social and cultural selves. Key aspects of relational practice include: judicious use of self-disclosure, recognition of both subjectivities, and recognition of enactments and active repair of ruptures (Benjamin 2018; Goldstein, Miehls and Ringel 2009; Mitchell 2000). In the therapeutic treatment process, impasses, enactments and ruptures are not only inevitable but provide fertile ground for growth (Safran and Muran 2000). Morey (2019) identifies that enactment-informed interventions such as recognition and acknowledgement via interpretation rather than avoidance or direct management of behavior are essential to therapeutic progress. Other researchers have found that the management of rupture—repair episodes was positively related to good treatment outcomes (Safran et al. 2001). In summary, when clinicians acknowledge the multiple subjectivities, recognize ruptures and attend to the repair, they can powerfully transform and facilitate meaningful clinical work. These principles provide fluid interactional framework for my clinical work in the interracial and intercultural field. They will be illustrated further in the following case example.

Case Example

Meeting of the Client and the Therapist

Outsiders on a Quest

In this section, I present the exposition of intercultural and interracial treatment focused on facilitating the client's self-development and growth from a composite case study. I will call the client "Michelle." The treatment dyad consists of the therapist, a female immigrant Vietnamese American clinical social worker, and the client (to protect confidentiality, an amalgam of clients), a young African American woman seeking treatment to manage severe psychosocial stressors in multiple domains of life as related to aspects of her social identities. While the client has explicitly stated she sought treatment from this clinician specifically because of her visibly Asian profile on the *Psychology Today* website, it is unknown initially whether the client (or the therapist) anticipated how intersecting social identities (race, ethnicity, class, religion, gender, and sexual orientation) of the client and clinician would simultaneously and mutually affect and influence each other. Following both intercultural and relational processes, it is necessary for the clinician and the client to acknowledge and negotiate their subjectivities and intersectionalities. As the treatment unfolds, the clinical tasks associated with facilitation of self-growth can be uniquely informed by both their intersectionality and how they manage the co-constructed experiences within the therapeutic encounters in this "third space" (Mattei 1999; Ogden 1994). As the treatment deepens, both the clinician and the client transform their work by acknowledging and negotiating their internalized beliefs and assumptions which promote growth and transform aspects of their selves (Benjamin 2018; Goldstein et al. 2009).

Michelle, an African American female in her late 20 s sought treatment due to feeling "stifled" and overwhelmed in her new job in a major Fortune 500 company. She reported she puts forth great efforts to be 'tough' and frantically acts to control negative feelings. She stated that the more she thought about how to take charge the more she panicked and needed to "gasp for air." In addition to work issues, she recounted intense anxiety, feelings of hopelessness and acute depression from a globalized sense of doom and isolation as she thought about coming out to her parents as a lesbian before she could enter into a romantic relationship.

In the first session, Michelle let me know pointedly that she sought treatment with me "because you are Asian, not Black or White." To her direct question whether I was born in the U.S., I said "no" for which she nodded appreciatively. Her slight gesture hovered in my mind intriguingly as if entrenched in what Winnicott termed primary maternal preoccupation (Winnicott 1956). I was preoccupied with what it meant for her in her choice and how she had viewed my social identities in relation to hers. What were her wants and needs, projections and hopes in a minority Asian American immigrant therapist? I recognized a curious feeling from being sought out in this specific way. I recognized a familiar ambivalence: wanting to be seen and wanting to be invisible. I wanted people to know that I was a refugee and immigrant who left her country holding onto a little hope in the mantra my parents had often extolled, "in America, you will get a fair chance at education and a better life." I also didn't want people to know that truth because I was fearful of the prejudices directed at a foreigner, an outsider, and ultimately, I was afraid that I would be treated as 'less than' rather than different.

Backgrounds and Perspectives

Michelle and I were different. Beyond visible racial and ethnic differences, we were also separated by our economic status, lineage, our upbringing and the environments where we grew up. I am a cisgender heterosexual woman, married with two young children. I grew up practicing Buddhism. When I was 13, my family and I began our lives again in America,

relying on social welfare in the forms of food stamps and aid for the first three months. My parents lived through the ravages of the American war. They have never been to college and I realized I could not rely on them to navigate the ways of the new world. Michelle grew up as the youngest of four living in the Midwest in a household with two successful Ivy-league educated African American parents. She reported struggling with the strict conservative Christian views in her family. Her parents placed great expectations on her to be productive and successful using the formula they knew: work hard to amass wealth and prestige in order to have a 'good life' despite racial oppression. Her father has repeatedly outlined strategies to eliminate useless emotions on the road to efficiency and success. Growing up, she felt there was never a possibility of sharing with her parents her doubts or fears whenever she encountered something difficult. She said her father had 'no patience for feelings and impressed upon her that she should not be like her mother, who was emotional and weak. A Winnicottian formulation would suggest that Michelle did not receive adequate holding, handling and presenting from her parents. A contemporary relational perspective would identify that Michelle did not receive reciprocity nor mutual regulation with her caregivers. Part of the clinical treatment plan would involve the corrective or reparation of this early misattunement and faulty object representation as well as attending to and reparation of enactments.

The Clinical Encounters

Great Expectations

Outwardly, it seemed that Michelle had succeeded. She earned her Master's of Business Administration from a top business school, worked and lived on her own for a few years. Yet the return to her hometown afterwards and initial reliance on her parents' connection for employment marks a reversal in the separation-individuation trajectory as well as a Winnicottian developmental regression for which she experienced great shame (Mahler 1968; Winnicott 1963a). As she fulfilled her obligation of visiting with her parents, the individuation process seemed to have collapsed whenever her autonomy was challenged and compromised. In sessions, she discussed at length how frustrated and angry she was when her parents pressured her to carry the family's professional careers, uphold the family's name and image as well as being guilted into spending every weekend with them. Her anger is understandable given the strong family expectations, further entrenching Michelle in false-self compliance and obscuring her true-self yearnings and ambitions. Given these dynamics with her parents, one wonders if the deliberate choice of finding a therapist who is not Black is an active effort to limit the transference of the old objects and their limited representations. Alternatively, perhaps in seeking to work with me—a different enough, new object—is an active desire to examine, acknowledge, negotiate, and organize her own disparate different aspects of herself.

The Going Home Dream

A few months into our work, Michelle shared a dream. In the dream, she was fatigued from numerous meetings with an Asian business counterpart and as the meeting adjourned, he asked her to give him a ride home. She became irritated but complied and drove him to the address he provided. To her surprise, the GPS led her to her childhood home. Inside her home, she wandered into her old room and found an adorable girl, about 5 years old, building a cardboard home by herself. The girl's face lit up and begged her to stay and play because she was so lonely. She could hear her parents calling to her to "leave the kid alone." As she left the room, the girl screamed in frustrated anger, "All these years! Aren't you tired of being angry and sad?" Seeing my rapt attention, Michelle quickly identified the 5-year-old girl as herself then began to talk about times growing up when she had been lonely and sad as her parents were busy with their careers and she was left to herself with projects they set up for her to do or left in the care of intimidating caregivers. She said her parents bought her things but she wished they would spend time and be with her. When asked what she made of her dream, she said, "It's all that Asian man's fault." It is probable in the dream condensation, the Asian business partner could be me, her Asian therapist who had asked her to talk about her childhood and forced her to "go home." In that moment, I registered her need to displace the cause of the intense feelings elsewhere as it was difficult to acknowledge the anger towards her parents or towards her therapist. Thus, I worked to maintain the holding environment. In my attempt to be a good enough therapist, I held her anger and sadness.

Then, she asked, "How did you do it?" I answered as if she had asked how I navigated my own immigration to the U.S. and subsequent life and construction of "home" in the U.S. She then redirected me noting that her question was about my ability to sit with her sadness and anger. Michelle's question can be interpreted as an active wish for a corrective or reparative emotional experience, that the therapist would be available and able to hear and respond to her other thoughts and feelings differently than her primary objects. Yet, in the conversation of "home", I became lost in my own reverie of my identity as an immigrant and my desire "to go home," that I lost the attunement and entered into a countertransference enactment (Ogden 1994). The clinician and the client were pulled by the vulnerable aspects of their affective and social selves.

The Third Space

The exchange illuminated a "third space" as co-constructed based on the intersection of their different social selves and experiences. I acknowledged the misattunement and attempted to repair. Michelle then expanded her exploration. She described that in high school she found the most comfort sitting with the Asian American students, therefore, she had hoped for that comfort when she chose me as her therapist. She clarified further that because of her family's wealth and her parents' social status, she did not experience a sense of belonging with other African American students yet, for all her resources, she was too black to fit into white spaces. I connected to her sense of not belonging, a feeling that I have known since coming to the U.S. It seems we have both inhabited this other, "third space."

The relentless pursuits of excellence her parents lived, modeled and expected of her were not unlike the 'model minority' yoke on me. Our experiences of individual and systemic racism, as we were not able to exist and function on our own behalf but often felt responsible for our collective people are examples of marginalization that built a powerful connection (Shonfeld-Ringel 2000). Despite our visible differences, there seemed to be a kindred similarity between how Michelle and I had navigated spaces; we often did not fit nicely into any given space but needed to straddle multiple ones. Our similar experiences of intense otherness heightened the empathic connection, and expanded space for exploration and integration of multiple perspectives (Tang and Gardner 1999; Yarborough 2017). In holding multiple perspectives in this fertile, safe, practicing ground, Michelle and I began to explore and co-create new possibilities (Ogden 1994).

Navigating Lonely and Unchartered Territories

In addition to similarities regarding issues of otherness, we were both navigating how to work and interact with others in a new way. During this treatment with Michelle, I started to engage with clients relationally, consciously acknowledged and made use of myself rather than striving for therapeutic neutrality. While I recognize the inevitable presence of our subjectivities and believe they can be catalysts for therapeutic change, I was afraid to let my White, male, classically-trained psychoanalyst supervisor know of my disclosures to Michelle. It was as if I had entered an unchartered, unsupported territory. I was seized by the fear of doing something wrong and not knowing. Yet, having heard dismissive and clinical rationalization of my particular cultural experience previously, I did not feel like I could talk to my supervisor about race and culture much less ask for support or guidance. The lack of space to talk and be supported in supervision was apparent yet not possible to discuss (Suslovic 2020; Tummala-Narra 2016). As an immigrant, for many years I believed my survival depended on my success and competence, submitting to the prescribed "model minority" trope. There had been no space for any margin of error, no room for mistakes and not knowing. If I was not smart enough or of use or of service, I feared that "they" wouldn't let me stay in this new country. The negative experiences of people ridiculing my accents, yelling, "go back to where you came from" have stayed with me and evoked fear and dread. The experience of being in this solitary clinical space, of holding both ends of anxiety and excitement in doing something new seems like a mirror to that of Michelle's process of building a professional and social life. Through this experience of intense clinical loneliness and a lack of support and guidance in supervision, I recognized similar dynamics for Michelle in the shape of loneliness and fear. When I recognized and managed my own uncertain terrain, I was able to facilitate "unintegration" and held the space for Michelle to unpack and process and navigate her unfriendly space (Winnicott 1962). It appears Michelle had actively and defensively split off undesirable aspects of herself (i.e., emotionality, gender identity and other ways in which she was not like her parents) and exiled them out of consciousness. A Kleinian treatment formulation would further include addressing the integration of experiences and disparate parts of the self that were previously disavowed. The countertransferential enactment alerted me to recognize in our parallel process a keen similarity. Relational treatment framework enabled me to acknowledge and recognize this mutual and fluid intersubjective experience, which mitigated our separateness and isolation.

Navigating "I Don't Know"

Michelle described the process in which she navigated her sexual orientation. She described her attempt to come out to her mother at age 23. Her mother told her that she was probably just questioning her sexual orientation and quickly changed the subject. She believed that her mother, who had been socialized and steeped in conservative religious beliefs could not accept her sexual orientation nor hold space for such contemplation or conversation. She recognized her mother's religious indoctrination, internalized homophobia, and thus retreated and lived in a state of rejection and pervasive doom. This rejection intensified the excruciating subjective pain of having been unseen, unheard and affectively unloved by her parents. The clinical treatment included excavation of suppressed negative emotions and experiences, re-examined internal and interpersonal yearnings, explored losses, as well as aspects of herself that she had othered and disavowed.

Three years into the treatment, Michelle allowed herself to enter into romantic relationships to find a partner. She

described attempts to join meet-ups, installed dating apps and allowed herself to try the dating scene for the first time in her adult life. She came to therapy in extreme distress and impatient with the process. She described frustrations with not knowing what to say and what to expect when on a date. She asked direct questions and became irritated when I redirected her to explore her feelings and expectations. I became frustrated and impatient with her direct questions and expectations of guidance. Challenges to technical maneuverings aside, her questions also pressed at my own traditionally gendered upbringing with strict expectations regarding modesty and repression regarding issues of sexuality. In my doctoral coursework, I described this challenge and an instructor questioned that as a heterosexual female, how prepared was I to help her navigate sexual orientation and relationships. Initially, I reacted in an arrogant defensive huff, "I did not need to be a lesbian to work with Michelle!" Upon further examination, I understood that while I did not need to identify as a lesbian to work with Michelle, I needed to recognize and understand what it was like for her. Acknowledging "I don't know" was objectively undesirable and it has a strong cultural countertransferential hold on me, yet, there was no other option (Lee 2005). I decided to balance the needs of my client against the concerns of my "not knowing", I acknowledged my hubris and my lack of experience of the online dating processes, my own heterosexism and privileges in the heteronormative milieu that shielded my ability to see, connect and empathize with her pain.

Intersectionality

Surprisingly, with my acknowledgement of "not knowing", Michelle began to relax. The frustration became less intense. Unlike her parents, I modeled for her a different and new way to engage with the unknown (Bromberg 2010). She began to allow herself to not know, to accept the process of trying to get to know someone, and to tolerate the experience. We processed the frustrations of not being able to use our intellectual competence for problem solving. She worked hard to address internalized homophobia in her, and in her parents and extended family toward same sex relationships. She reached out to an aunt whose gender and sexual orientation that she believed everyone in the family sees but does not acknowledge. Gradually, with increased confidence, she began the conversations and came out to her father and mother. Being able to speak the truth aloud and having her parents see and accept her sexual orientation was a major turning point in our work and her own developmental progress. Michelle said she felt closer to living with a sense of true-self and can envision a life that is more real.

In the last frontier, Michelle and I acknowledged and negotiated the issue of race, particularly her experiences of racism, discrimination, oppression and privilege. She applied for a leadership position but lost out to a white colleague. When she processed the experience, she identified their equal experience and knowledge but resigned with a sigh, "I think it is a white place." When I asked her to talk about her experiences of racism, she was very reluctant, citing, "I am not interested in the Oppression Olympics." We had worked together for more than 5 years and I believed we had a strong enough alliance so I pressed her to expand. She was reticent. I noticed this change and wondered about this dynamic aloud. She then stated, "my life, really, is good; I don't have much to complain." This phrase was almost verbatim to what her parents had told her years ago whenever she voiced any complaint. I asked if it was difficult for her to talk about how she had been discriminated against and oppressed in my presence, an immigrant, who she thought might have endured oppression and lack of privileges and that ostensibly, compared to me she did not have much to complain about.

I named that to have some class privileges did not exclude her from voicing her disagreement or to express her anger at having been treated unfairly based on race. In fact, as Goodman (2014) points out, "privilege and oppression operate simultaneously… The intersectional color that gets created when intersectional threads are interwoven reflects not just the interplay of identities but the interactions of different positions within systems of power" (p. 102). In the treatment with Michelle, we acknowledged the complicated intersections of intersectionalities, our intersubjectivities based on our social identities and together created a larger space where empathic understanding eased the sadness and pain of isolation from being othered and oppressed. Just as in her childhood, her wealth did not prevent her from being discriminated against. My hardships did not invalidate hers. In the clinical setting, there is ample space that the client and the clinician can work and learn together, that they are more than "doer" and "done to" (Benjamin 2018). In the end, she acknowledged that there were so many experiences and aspects of herself that made up her, as Michelle. It is apparent that the intercultural and interracial treatment arena is a site of tension and negotiations of subjectivities and intersectionalities. As all individuals have certain privileges and vulnerabilities, differently oppressed, clinicians need to skillfully navigate and support their clients better.

Facing Assumptions and Promoting Growth

In this work with Michelle, we had made assumptions about each other due to our different social identities, yet we both shared experiences of the "third space" related to otherness. Perhaps our differences set up a contrast and effectively attended to issues Michelle had consciously and subconsciously avoided. When Michelle recognized, accepted and celebrated her many self-states and disparate aspects

of herself, she moved closer toward a more integrated and cohesive self. In my work to facilitate her self-development and growth, I have also grown personally and professionally. In a parallel process, I examined issues I subconsciously avoided and the ways my intersectionality reflects my lived experiences of oppression that inform my use of self in the treatment arena. Due to the effects of insidious racism and colonization, I have been conditioned to seal off my own ethnic and cultural ideals, perspectives, values and identities to fit in with the dominant, normative Western thoughts. Just as I have taken Michelle to her childhood home, attending to cultural countertransference in my use of self has allowed me to acknowledge my bicultural self and incorporate Eastern sensibilities into my Western clinical training in a comprehensive and holistic way.

In seeing each other, both clinician and client had to examine assumptions about themselves and each other. When we acknowledged our assumptions, we also attended to and repaired enactments. The intercultural and interracial dyad acknowledged and revealed our many social identities and co-created a more just and therapeutic space as well as increased flexibility in navigating the sociocultural political world outside.

Implications for Practice, Education and Research in Social Work

The use of self is a powerful tool for social workers, yet for many ethnic and racial minority clinicians, their sense of self contains personal, psychological, social, and cultural aspects that they must acknowledge and negotiate as they enter into the clinical arena. Certainly, this task and work will look different for clinicians who hold mostly dominant identities than it will for clinicians who do not. In order to facilitate growth for their clients, social workers must acknowledge and examine the assumptions about the other and within themselves in order to skillfully navigate the minefield in the heat of the clinical moment. They must recognize and transform their lived experience of intersectionality to effect a culturally and socially just clinical social work practice.

Clinical social workers, especially those with different racial and ethnic identities should continue to amplify their voices, and share their perspectives and their work. Likewise, there must be spaces for these voices to be shared and heard. Clinical social work education and training curriculum must also center the lived experiences and clinical wisdom of racial and ethnic minority clinicians, educators and researchers as a commitment to diversity as outlined in the Code of Ethics. I imagine this article and others cited in this paper would add much to further the conversation about culture and race in clinical practice as well as other areas of social work. Just as this paper demonstrates, the interdependence and co-construction by the client and the clinician in the clinical setting extends to the interdependence of clinical practice, research, and education. We must train diverse students and equip them with more substantive knowledge and practices in order to meet the myriad needs of clients within our current complex, richly diverse and therefore contentious world. We will all gain from learning, practicing and teaching with these perspectives in mind.

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